Limitations on Services Provided

1. Inpatient Hospital Services

A. Private Hospitals

1. Those items and services furnished are defined as those included as covered under Inpatient Hospital Services in 42 CFR 440.10. Inappropriate level of care services are not covered.

2. Services provided in connection with dental or oral surgery services will be limited to those required for emergency repair of accidental injury to the jaw or related structures.

3. Services provided in connection with surgical procedures for cosmetic purposes (except for emergency repair of accidental injury) will be included only by prior authorization issued by the State Agency.

4. Organ transplant services require prior authorization, and are limited to the guidelines set forth in the District of Columbia Standards for the Coverage of Organ Transplant Services under the D.C. Medicaid Program.

5. Reimbursement for covered hospital days is limited to one day prior to surgery, unless medically justified. Hospital claims with an admission date more than one day prior to the first surgical date will pend for review by medical staff to determine appropriate medical justification. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for additional post-operative days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

6. Reimbursement will not be provided for weekend (Friday/Saturday) admissions, unless medically justified. Reviewed hospital claims with admission dates on Friday

or Saturday will be pended for review of these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

B. Public Hospitals

1. Those items and services furnished are those included as covered under Inpatient Hospital services in 42 CFR 440.10 by a hospital providing such services that is owned and operated by the District of Columbia. Unless specifically stated within the State Plan, public hospitals should refer the Health Insurance Manual 10.

2. The program may exempt portions or all of the utilization review requirements of subsections (b), (c), (h) and (i) as it relates to recipients under age twenty-one (21). In accordance with the requirements of 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to medical documentation requirements.

3. Services provided in connection with dental or oral surgery services will be limited to those required for emergency repair of accidental injury to the jaw or related structures.

4. Services provided in connection with surgical procedures for cosmetic purposes (except for emergency repair of accidental injury) will be included only by prior authorization issued by the State Agency.

5. Organ transplant services require prior authorization, and are limited to the guidelines set forth in the District of Columbia Standards for the Coverage of Organ Transplant Services under the D.C. Medicaid Program.

6. Reimbursement for covered hospital days is limited to one day prior to surgery, unless medically justified. Hospital claims with an admission date more than one day prior to the first surgical date will pend for review by medical staff to determine appropriate medical justification. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for additional post-operative days.

Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

7. Reimbursement will not be provided for weekend (Friday/Saturday) admissions, unless medically justified. Reviewed hospital claims with admission dates on Friday or Saturday will be pended for review of these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

2. Outpatient Hospital Services

a. Surgical procedures for cosmetic purposes (except for emergency repair of accidental injury) will be provided only by prior authorization issued by the State Agency.

b. Dental or oral surgery services will be limited to the emergency repair. Emergency repair is defined as an accident which caused injury to the jaw and related structures.

c. Surgical procedures meeting the standards specified in 42 CFR 416.65(a) and (b), and included in the list published in accordance with 42 CFR 416.65 (c) shall be reimbursed only if provided in facilities meeting the requirements of 42 CFR 416, Subpart C.

Surgical procedures meeting the standards specified in 42 CFR 416.65(a) and (b), and included in the list published in accordance with 42 CFR 416.65(c) shall not be reimbursed on an inpatient basis.

Surgical procedures meeting the standards as specified in the 42 CFR, 416.65 (a) and (b) and included in the list published in accordance with the 42 CFR, 416.65 (c) shall not be reimbursed unless certified by the District of Columbia's Certification Program.

3. Other Laboratory and X-ray Services

a. X-ray, radium and radioactive isotope therapy will be provided only in facilities approved for such therapy by the State Agency.

b. Services primarily for, or in connection with, cosmetic purposes will be provided only with prior approval by the State Agency.

c. Services primarily for, or in connection with, dental or oral surgery services will be limited to those required incidental to the emergency repair or accidental injury to the jaw and related structure.

d. The independent laboratory services are limited to those laboratory procedures and tests within the specialties and subspecialities for which the independent lab is certified as a provider for laboratory services under Title XVIII of the Social Security Act.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Region III
P.O. Box 7760, 3535 Market St.
Philadelphia, PA 19101

NOV 19 1984

HCFA REGIONAL MEDICAID LETTER NO. 84-14

SUBJECT: Medicare Guidelines for Coverage of Liver Transplants

HCFA recently issued a Medicare Coverage Issues Appendix instruction to implement our current policy that liver transplantation is no longer considered experimental for children under age 18 with extrahepatic biliary atresia or any other form of end-stage liver disease. This instruction is effective for services rendered on or after February 9, 1984. Children with malignancy extending beyond the margins of the liver or those with persistent viremia will be specifically excluded from coverage because the existing data show potentially low benefits for these indications. Liver transplantation for adults is still considered to be an experimental procedure and is not covered by Medicare.

Everett F. Bryant
Regional Administrator

certified as a provider to laboratory services under Title XVIII of the Social Security Act.

4.a. Skilled Nursing Facility Services (Other Than Services in An Institution for Mental Diseases) for Individuals 21 Years of Age or Older

Those items and services furnished and defined as those included as covered under Requirements for Coverage of Extended Care Services under Hospital Insurance Services in Section 214 of the Medicare Skilled Nursing Facility Manual (HCFA Pub. 12) issued under Title XVIII of the Social Security Act.

4.b. Early and Periodic Screening and Diagnosis of Individuals under 21 years of age, and treatment of conditions found are provided with no limitations.

4.c. Family planning Services and Supplies for individuals of childbearing age are provided with no limitations.

5. Physicians' Services Whether Furnished in The Office, The Patient's Home, A Hospital, A Skilled Nursing Facility or Elsewhere

a. Elective procedures requiring general anesthesia will be provided only when performed in a facility accredited for such procedures.

b. Surgical procedures for cosmetic purpose (except for emergency repair of accidential injury) will be provided only by prior authorization issued by the State Agency.

c. Medicaid payment is prohibited for services connected with providing methadone treatment to patients addicted to narcotics unless such treatment is rendered by providers specifically authorized to do so by the Alcohol and Drug Abuse Services Administration of the Department of Human Services.

d. Gastric bypass surgery requires written justification and prior authorization.

e. Assistant surgeon services require prior authorization by the State Agency.

f. Reimbursement for inpatient consultations or inpatient hospital visits by a physician to a patient whose level of care has been reclassified by the Peer Review Organization from acute to a lower level are not covered. Only those visits determined medically necessary will be reimbursed.

g. Sterilizations are not covered if the patient is under age twenty-one.

h. Organ transplantation requires prior authorization in accordance with the District of Columbia Standards for the Coverage of Organ Transplant Services as indicated in Attachment 3.1E of this state plan.

i. Certain surgical procedures (examples: reduction mammoplasty, intestinal bypass for morbid obesity, and insertion of penile prosthesis) require prior authorization.

j. Reimbursement for induced abortions is provided only in cases where the life of the mother would be endangered if the fetus were carried to term, or the pregnancy occurred as a result of rape or incest and when the claim is accompanied by the following documentation:

   1. Documentation that services were performed by a provider licensed to provide such services; and

   2. Written documentation from the treating physician that the life of the mother would be endangered if the fetus were carried to term; or

   3. Documentation that the pregnancy occurred as a result of rape or incest. For purposes of this requirement, documentation may consist of official reports; a written certification from the patient that the pregnancy occurred as a result of rape or incest; certification from the physician that the patient declared the pregnancy occurred as a result of rape or incest; or certification from the physician that in his or her professional opinion, the pregnancy resulted from rape or incest.

3a

Reimbursement shall be made according to the fee schedule amount and shall cover all services related to the procedure including physician fee(s), laboratory fee(s) and counseling fee(s).

6. Medical Care and any other type of Remedial Care Recognized Under State Law, Furnished by Licensed Practitioners Within The Scope of Their Practice as Defined by State Law

a. Podiatrists' Services

The limitations on routine foot care are the same as the limitations under Medicare and delineated in the Medicare Carriers Manual (HIM-14) and the Medicare Intermediary Manual (HIM-13). Special treatment should be prior authorized by the State Agency.

b. Optometrists' Services

Limited to specific services except where prior authorization is made by the State Agency. Services are further limited as follows:

1. Contact lenses must be prior authorized by the State Agency.

2. Eyeglasses are limited to one complete pair in a twenty-four (24) month period. Exceptions to this policy are:

(a) Recipients under twenty-one (21) years of age;

(b) Whenever there is a change in the prescription of more than plus or minus .5 (one half) diopter, and

(c) Broken or lost eyeglasses.

3. Special glasses such as sunglasses and tints must be prior authorized by the State Agency and justified in writing by the optometrist. Special tints and sunglasses are not allowed in addition to untinted eyewear.

In addition, the optometrist must adhere to the dispensing procedures in the providers Medical Assistance Manual.

7. Home Health Services ?

a. A "Home Health Agency" is defined as a public or private agency or organization which meets the requirements of Medicare.

b. Services of a home health aide must not exceed four (4 hours per visit per day, unless prior authorization is given by the State Agency. ?

c. Medical Supplies, Equipment, and Appliances for use of the patients in their own homes are limited to those items on the Durable Medical Equipment/Medical Supplies Procedures Codes and Price list, except where prior authorization is given by the State Agency.

in the home must be provided

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency, or by a facility licensed by the State to provide medical rehabilitation services.

(1) Physical therapy is provided as long as it is a part of a plan of treatment and provided in a hospital, skilled care facility, intermediate care facility or through a home health agency.

(2) Occupational therapy is provided as long as it is a part of a plan of treatment and provided in a hospital, skilled care facility, intermediate care facility or through a home health agency.